APPLICATION FOR SOUTH DAKOTA RISK POOL HEALTH COVERAGE

Eligibility – To be considered an eligible individual, you must satisfy **all** of the following criteria:

- You must have had 12 months of continuous creditable coverage. Continuous coverage means you have not had a break in coverage of 63 or more days. Types of continuous coverage includes:
  - An employer-based health plan
  - An individual health plan
  - Medicare or Medicaid
  - Chapter 55 of Title 10, United States Code (Champus)
  - Indian Health Services or a tribal organization
  - A state health benefits risk pool
  - Chapter 89 of Title 5, United States Code (FEP)
  - A public health plan
  - A church plan
  - A college plan that is not a limited benefit plan

  Note: Some limited benefit plans and dread disease plans are not creditable coverage. Short-term major medical and some policies that provide less than comprehensive major medical coverage apply toward the 12 months of creditable coverage requirement, but cannot be the coverage immediately prior to the effective date of the Risk Pool policy if the coverage was an individual plan. You should ask the assistance of your agent or contact the Risk Pool for further information as to whether you may qualify if you have one of these types of plans.
- You must apply within 63 days of losing your prior coverage.
- You must have **used up any COBRA or state continuation coverage** for which you were eligible.
- You are **not covered** under a group health plan, Medicare, Medicaid, or any other form of health insurance.

  Note: If you are eligible or may be eligible for other health insurance you may want to apply or contact the Risk Pool for further information.
- Your most recent coverage was **not** terminated for nonpayment of premium or fraud.
- You must be a resident of this state. Examples of proof of residency include your driver's license, state issued ID card, and voter registration.

A. Eligibility Checklist (Attach applicable certificates of coverage showing most recent 12 months of coverage, letters of coverage termination, and proof of residency to confirm eligibility.)

- I have involuntarily lost creditable coverage (as listed above) ☐ Yes ☐ No
  (If no, you are not eligible for coverage.)
  Name of Insurance Carrier or Program:_____
  Coverage or program effective date:_____
  Coverage or program termination date:_____
  Name of Covered Individuals:_____
- Why did or why will your coverage terminate?
  - HMO coverage is no longer available because you moved from the service area ☐ Yes ☐ No
  - Insurance carrier is no longer renewing coverage in South Dakota ☐ Yes ☐ No
  - Insurance carrier is not renewing employer group coverage because group no longer meets eligibility requirements ☐ Yes ☐ No
  - Employer is no longer providing group insurance ☐ Yes ☐ No
  - COBRA or South Dakota Continuation expired ☐ Yes ☐ No
  - No longer eligible for employer group coverage and COBRA or S.D. continuation coverage not available ☐ Yes ☐ No
  - No longer eligible for Medicaid ☐ Yes ☐ No

B. Membership Information

Name (First, Middle, Last				
Date of Birth	Social Security Number	Home Phone	Sex (M or F)	
Mailing Address		City	State	Zip
Physical Address (If different from mailing address)		City	State	Zip

C. Enrollment Application

Note: Changes to your deductible may only be made to take effective at the beginning of the plan year (July 1). You **may not** decrease deductible amounts after your initial selection. Coverage is not effective until notice is received from the Plan Administrator and the actual effective date may vary from the requested effective date.

Plan A - $1,000 deductible☐
Plan B - $3,000 deductible☐
Plan B - $3,000 deductible with HSA qualifying option ☐
Plan C - $10,000 deductible ☐

Requested effective date for coverage ____/____/_____

D. Tobacco Non-User Declaration

- I have used tobacco products (includes all tobacco products and is not limited to smoking) during the 12 months immediately preceding the date of this application. ☐ Yes ☐ No

If you answered "No" to the above question, you may be eligible for a special tobacco non-user rate. You may be required to recertify your non-user status in the future. If it is determined that the tobacco-use status is misrepresented or inaccurate during the initial two years, the difference in premium will be retroactively collected from the date you first received the non-user rate. If determination is made beyond the two-year

period, your premiums will increase to the tobacco-user rate on the first of the month following the determination. If you resume smoking or using tobacco products, you must notify the Risk Pool administrator.

E. Other Insurance (Attach separate sheet if additional space is needed.)
Health benefits can be provided by other insurance policies, coverage or programs that pay benefits when a certain diagnosis is made, a certain dollar threshold has been met, a certain procedure is performed, or certain charges are incurred. Examples include cancer policies, hospital indemnity policies, supplemental insurance (AFLAC type policies) and others.

- I currently have other types of coverage. ☐ Yes ☐ No

Name of insurance carrier or program:_____
Type of coverage:_____
Coverage or program effective date:_____
Coverage or program termination date:_____

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F. Agreement and Authorization
I have read, or had read to me, the completed application. I certify that I am legally authorized to apply for coverage for myself in this application. I also hereby agree that (1) I represent that all information shown above is correct, and having read this form and the above statements and answers and any attachments, I represent that they are true and complete to the best of my knowledge and belief, and agree that this application (and any other required parts) shall be the basis for any plan provided; (2) If I made any false statements or misrepresentation, or have failed to disclose or have concealed any material fact, coverage provided under this application may be considered void and the allowance of benefits will be refused; and (3) I understand that I must pay the appropriate premium amount in advance to maintain coverage and have included a signed ACH form and premium for the first two months of coverage. If this application is declined and a plan is not provided, the only obligation of the Risk Pool will be to return any premium paid.

I authorize any health care provider to release medical records to the Risk Pool or its designee when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I authorize any insurance carrier to release records pertinent to prior health or medical coverage provided under that plan, including limited benefit plans. I further agree upon request to furnish all information required to administer this coverage.

Applicant's Signature_____ Date____/____/____

For agent use only (If applicable):
Printed Name_____ Agent Signature_____
☐ Pay agent license #_____ ☐ Pay agency FEIN#_____
Payee name & mailing address_____
Agent Phone #_____ Agent Fax # _____